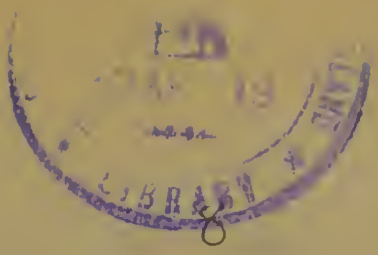

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THE PRESENT POSITION OF OUR KNOWLEDGE WITH REGARD TO THE TREATMENT OF UTERINE FIBROIDS.

BY ALBAN H. G. DORAN, F.R.C.S.,
Surgeon to the Samaritan Free Hospital.

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THE advance made in scientific gynæcology since ovariotomy became an established operation must be reckoned as one of the most satisfactory features in medical progress during the last quarter of the nineteenth century. In order to be convinced of the magnitude of this advance we need only compare the recent discussion on deciduoma malignum at the Obstetrical Society of London with the debates on other subjects preserved in the earlier volumes of that Society's *Transactions*. The development of abdominal surgery beyond the limits of ovariotomy is closely linked with the evolution of antiseptic and aseptic surgery. The treatment of fibroids has been deeply influenced by this development. For several years its progress was relatively slow, because operations on the kidney and gall-bladder proved easier and less perilous than hysterectomy for fibroid as then practised. Since 1890, however, technical improvements and increased experience have rendered hysterectomy far less dangerous to the patient's life. In consequence wholesale extirpation of fibroids is practised at the present day, as the pages of the medical press show week by week. A theory has been advanced that all fibroids should be removed. This theory is stoutly contested by men of experience. The truth lies between the two opposed opinions, and the discussion of these opinions may conveniently form the basis of this contribution, as it will throw some light on the present position of our knowledge with regard to the treatment of uterine fibroids. The evidence gained by the results favourable or otherwise of operative treatment has proved most instructive to medical science.

A fibroid demands no immediate treatment when its sole symptom is its own existence. Champneys' statistics show how many women live and die with dormant fibroids. One

P 8152.—2.

of the boldest of operators, Murdoch Cameron, maintains that in his own experience not more than one third of the cases seen require surgical interference.[1] By "cases seen" he implies that many are not seen, the tumour remaining undiscovered. Howard Kelly, another renowned operator, emphatically stated at the recent Congress in Madrid that the man who maintained that every fibroid should be removed was greatly mistaken. When a fibroid of small size is detected accidentally, and it is clear that the patient's malady has nothing to do with the tumour, its removal is not justifiable.

The course of a fibroid, however, is extremely uncertain. We can safely prophesy what will happen if an ovarian cyst or a cancerous cervix be left alone, whilst even the most experienced amongst us can never feel sure that a fibroid hitherto symptomless will or will not remain quiescent. I strongly support the opinion that it is not right to urge an operation, when no symptoms are present, simply to secure the patient against what Dr. Herman calls "some contingent, but improbable dangers." None the less do I hold to a second opinion that the most quiescent fibroid requires watching. Our duty to the patient is to tell her so, and to induce her to remain under our own observation, or under the care of another who is in a position to watch and write down notes of the growth or diminution of the tumour. We must impress upon her mind the truth that the fibroid is doing no harm. We must further warn her that it may do a great deal of harm some day. But we must never frighten her by conjuring up the bugbear of cancerous degeneration or the certainty of a speedy increase

[1] "An Address on some Points in the Natural History of Uterine Fibroids." *Lancet*, Vol. I., 1900, p. 147. "The Past and Present Treatment of Uterine Fibroids." *Brit. Med. Journ.*, Vol. II., 1902, p. 1153.

Since the above paragraph was written Mr. Mayo Robson remarked in his Address in Surgery at the Swansea meeting of the British Medical Association: "As usual, the best course is the middle one; many cases need no treatment, whilst others, when growing rapidly or when associated with free bleeding or pressure-symptoms, demand operation." Professor Stephenson declared at the same meeting that he had watched cases where women had carried fibroid tumours for 30 and 40 years with little inconvenience. Professor Howard Kelly recently observed: "I note with regret to-day an increasing tendency to sacrifice small myomatous uteri, which in my own judgment either require no operation at all, or, at the most, call for myomectomy." ("The Selection of Methods in Abdominal Hysterectomy." *Journ. of Obstet. and Gyn. of the Brit. Empire*, Oct., 1903, p. 343.)

of the tumour to colossal proportions. We know that the chances of the first complication are extremely rare, and the risk of the second but slight; therefore in wilfully magnifying such possibilities we should be guilty of gross prevarication.

In considering any patient's condition and interests, we must be very wary about the opinions of others, however authoritative they may seem. The experienced physician and the successful operator can never be wholly free from bias, and in this case they ever tend to oppose each other. The physician has treated women in comfortable circumstances, counteracting to the best of his ability the effects of years of uterine hæmorrhage and the discomforts of a bulky tumour. His patients may feel reasonably pleased with him for his treatment; nevertheless many of them would undoubtedly have been the better for early hysterectomy. Yet a doctor in his position cannot be expected to recognise that truth. The keen operator is prejudiced in the opposite direction. He shows his numerous recoveries and his low mortality, and is sure that recovery is full proof that the operation was necessary and justifiable. Yet a woman who has recovered from hysterectomy for fibroid may become a victim to subsequent complications which will entail far more discomfort than that which was caused by the presence of the tumour.

The opposing arguments which the physician and surgeon can bring forward must be duly scrutinised. The surgeon can rightly urge that the patient who has submitted to operation feels free from the burden of mental worry caused by the presence of a tumour. This burden is no fiction. Several of my own patients have volunteered the declaration, long after convalescence, that they were restored to a peace of mind which they had lost for years. As long as the tumour is present, after the patient has become aware of its existence, she cannot feel quite easy. A successful operation, then, usually means the restoration of mental comfort to the patient, but it involves many more benefits. The tumour being removed, the patient is safe from numerous troublesome, pernicious, obstinate, and sometimes dangerous complications to which the growth might have given rise had it not been extirpated. Supposing that such complications had already existed, and consequently harassed the patient before hysterectomy was performed, the

operator can feel fairly sure a year later that, had the operation been postponed to that date, its risks would have been greater. This assurance will apply far more surely to each succeeding year, even for some time after the menopause, for, although the newer theory may have been pressed too far, Kleinwächter, its earliest supporter, was quite correct when he insisted, on wide clinical experience, that the change of life does not necessarily cure fibroids.

On the other hand the physician who opposes operation when the tumour is unassociated with any complication, and is of small dimensions, has arguments of considerable force in his favour. The growth of a fibroid is not deadly, as is the case with a cancer; nor is it regular and certain to entail complications, one of which must at length prove fatal, as is the case with an ovarian tumour. The impossibility of calculating the future growth of a fibroid is put too much in the background by the advocates of hysterectomy. The operation itself is, at the best, no light experience, for even under the most skilful and kindly nursing the first few days are distressing to the patient. Hernia of the cicatrix, to be presently discussed more fully, is ever a possible after-result. Intestinal obstruction, the most perilous of all complications, is always possible, whatever method of operation be adopted. Another sequel of hysterectomy, sometimes occurring a year or more after convalescence, is the discharge of ligatures in very inconvenient directions. After enucleation of a fibroid from the posterior layer of the broad ligament many ligatures have to be applied to bleeding points in the pelvic connective tissue. Infection of these sutures by the Bacillus coli is always possible, for connective tissue, unlike peritoneum, is not very tolerant of foreign bodies.

The gravest possibility, however, when hysterectomy has been performed, is the advent of psychical disturbance. Hence close enquiry should be made about the patient's previous history; and even when that has been done, it may turn out that her friends have deceived us. The question of the management of the ovaries is, in respect to this complication, specially important; it will be discussed presently. Here it is sufficient to bear in mind that hysterectomy for fibroid is decidedly more dangerous than double ovariotomy when the patient's mental condition is unsatisfactory.

Such are the more important arguments for and against operation when a patient has a fibroid which is not threatening to give trouble. A few words may be said about treatment where an operation does not seem urgent.

This "treatment" is purely symptomatic. Light, nutritious diet, with as little red meat as possible, is well suited to such cases. Certain mineral waters are of indirect service. The advocates of electricity claim triumphs, but its application requires great experience, whilst the results are often doubtful, and in some cases which I have observed distinctly bad. When bleeding is present, ergot is not to be despised, especially if given in moderate doses with the ingredients so mixed that the active principle is not decomposed long before the physic is swallowed. There are fortunately means of administering ergot with something approaching precision. Large doses in any form are harmful, and when cardiac disease is present ergot is contra-indicated.[1] Chloride of calcium is vaunted by some authorities, but its method of action is uncertain, and the benefits derived from it doubtful. An abdominal belt, to support the tumour anteriorly, is always advisable.

Thus "treatment" is simple enough, for we may safely discard a very large number of remedies in which authorities (and others) have put their trust on insufficient grounds. As long as the patient keeps well, the tumour will keep well as a rule. But the exceptions are large; and the growth may take on certain well-known changes, such as sudden increase in size, involving severe pressure-symptoms, or it may give rise to exhausting hæmorrhages or to other harmful complications.

Let us, therefore, now consider operative treatment, which is demanded at once when bad complications are present, whilst its necessity is ever within the range of possibility when a fibroid is still without any other symptom besides its presence.

Not many years ago the operation of hysterectomy was attended by a frightful mortality. The practice was introduced of amputating the ovaries and tubes in cases of bleeding fibroids to check the hæmorrhage and arrest the growth of the tumour; and with the latter aim the same operation was undertaken

[1] *See* "The Relations of Organic Affections of the Heart to Fibro-Myoma of the Uterus." By Dr. T. Wilson. *Trans. Obst. Soc. Lond.*, Vol. XLII., 1900, p. 176. This excellent treatise deserves the full attention of every practitioner.

in cases where there was no escape of blood. Its advocates insisted that no ovarian tissue must be left behind. In this theory lay the weakest point of the operation, when duly analysed as to its technique and to its after-results. I have endeavoured to make clear elsewhere[1] that, owing to the anatomical relations and the structure of the ovarian ligament, it is in most subjects impossible to avoid leaving some ovarian tissue behind. Yet I have had eminently successful results, when a small piece of ovarian tissue had unavoidably been left on both sides. It not rarely happens that neither ovary can be removed, owing to their relations to a big, vascular fibroid; often 10 or 15 years ago one was amputated and the other found to be irremovable. I have followed up several cases where one ovary only could be taken away, and in more than one the results were quite satisfactory, for bleeding ceased and the tumour diminished in size. The theory that in such cases the ovary left behind was physiologically dead, being flattened out under the fibroid and consequently atrophied, I know to be quite invalid, for in some of the cases in question the ovary was not flattened out, but projected amidst a mass of engorged veins from the surface of the tumour, whilst I have noted that ovaries squeezed out flat between a big tumour and the bony pelvis may be full of follicles, and contain normal corpora lutea. One limitation admitted by the advocates of oöphorectomy for fibroids was the situation of the tumour in the uterus; if in the lower segment or cervix, removal of the ovaries would, they maintained, be useless, since a new growth in those parts is supplied by the uterine artery, whilst it is the ovarian vessels that are tied in this operation. It happens that I have had good results in more than one case where the growth was in the lower segment and the fundus free. On the other hand I have seen the most careful amputation of the appendages in cases where the fibroid lay above the lower segment followed by no good result. The frequency of what may justly be called "cure" in cases where the principles of the operation were not, or could not be carried out, has convinced me that the

[1] Harveian Lectures, Lecture I., *Lancet*, February 7, 1903, paragraphs headed "Surgical Anatomy of the Broad and Ovarian Ligaments" and "Oöphorectomy for Fibroids and its Teachings." These lectures include a summary of my own operative and clinical experiences in the treatment of fibroids.

benefits of oöphorectomy for fibroids were largely due to some other factor than removal of the ovaries. That factor has not yet been revealed. Certain eminent authorities[1] still practise this operation, claiming good results, but precise statistical evidence is wanting.

When the tumour itself is to be removed, it may be enucleated through its mucosa and drawn out at the vagina as though it were a polypus. Should this procedure be impracticable or inadvisable, there remain several operations termed myomectomy, vaginal hysterectomy, supra-vaginal hysterectomy and panhysterectomy.

The first is logically the best, being essentially conservative. When the tumour is a pedunculated, sub-peritoneal growth, it may be treated like an ovarian tumour. It is not always easy, however, to stop hæmorrhage effectually, and it occasionally proves safer to fix the stump of the pedicle to the lower angle of the abdominal wound than to let it go back into the peritoneal cavity. When the tumour is sessile, myomectomy means enucleation. The main objection to enucleation is its difficulty and risk. An expert accustomed to operations on the female organs and with all the advantages of an aseptic technique at his disposal may succeed in enucleating fibroids of considerable size through long incisions made in the uterine wall, but the operation is not satisfactory in the hands of less experienced operators.

The propriety of removing a uterus, subject to a small fibroid, through the vagina is still under debate. Many teachers urge that, when the uterus and tumour form a mass small enough to be removable in that manner, no operation is justifiable. This objection, we must remember, does not apply to little fibroids which cause much bleeding or give rise to general debility through necrotic changes. This operation is not always practicable, so that the operator may find himself obliged to make an abdominal wound in order to remove the diseased uterus. It must be allowed that experts in vaginal surgery have had good results in the practice of this operation, but too much has to be performed in the dark.

Panhysterectomy is ideal as regards completeness. The

[1] Murdoch Cameron, *loc. supra cit.* Gerald Garry claims to have observed very bad after-results. *Brit. Med. Journ.*, Vol. II., 1902, p. 1372.

cervix is removed and therefore cannot become the seat of cancer, nor can its stump slough, or undergo other pernicious changes owing to infection of ligatures in its substance, or be the cause of intestinal obstruction through adhesions. Its advocates, on doubtful grounds, consider that there is less danger from hæmorrhage than in supra-vaginal hysterectomy. But panhysterectomy is a long operation even in the hands of experts.[1] The after-results are not always satisfactory. I examined, a few years ago, a healthy young woman, aged 25, who three months previously had undergone panhysterectomy at the hands of an eminent foreign operator. Painful contraction of the vagina had developed and there was much pricking in the cicatrix. I have heard of similar complications in other cases. As a good deal of tissue in the pelvis is sewn up, leaving a ridge in the pelvic cavity, dangerous adhesions are always possible. It must be admitted, however, that there is less risk of this complication than when the cervix is not entirely removed. With more experience surgery may establish panhysterectomy as a valuable mode of procedure, but it is not yet in universal favour.

The supra-vaginal operation with the serre-nœud or elastic ligature was once very popular and still has a few advocates. Unfortunately the wire was an instrument of torture as more than one patient informed me. The stump sometimes sloughed, so as to infect the peritoneum, and a bad hernia often developed in the lower angle of the abdominal wound.

Altogether, the retro-peritoneal variety of supra-vaginal hysterectomy is the simplest and best operation for the removal of a fibroid uterus. The term "retro-peritoneal," or "sub-peritoneal," is advisable, for the stump is placed behind or under the peritoneum, outside its cavity. I admit that this principle of making everything concerned with the stump as extra-peritoneal as possible must be qualified; thus, it is better that the blood which always oozes from the stump for a few hours after the operation should flow into the peritoneal cavity than accumulate in the pelvic connective tissue. Still, when the operation is thoroughly successful, the

[1] Herbert Spencer: "Total Abdominal Hysterectomy (especially by Doyen's method) for Fibromyoma Uteri; with Notes of 14 Cases." *Brit. Med. Journ.*, Vol. II., 1902, p. 1131.

stump becomes an absolutely retro-peritoneal or sub-peritoneal structure.

A detailed account of this operation would be out of place here as this article deals with our knowledge of the treatment of fibroids, whilst retro-peritoneal hysterectomy is spoken of here mainly as the best surgical procedure, taking all things into consideration, when radical measures are demanded. A few words, however, may be said about certain factors of importance in regard to the operation, namely, the abdominal wound, the uterine flaps, the treatment of the ovaries, and the question of sutures.

The abdominal incision would seem to demand no special notice, seeing that it is made in other operations besides hysterectomy. We may profitably bear in mind, however, the truth that the parietes are usually very vascular in fibroid uterine disease; hence bleeding vessels should be carefully secured by pressure-forceps left on for a few minutes. Silk ligatures are, for evident reasons, objectionable. The incision should always be made long enough to allow of the extraction of the fibroid without bruising of the recti.

The uterine flaps need not be cut long; it seems best to fashion them of a length just sufficient to include a little of the tissue of the body of the uterus—mucous membrane as well as muscular wall. This method is in accordance with a theory on which more will be said in relation to the treatment of the ovaries in hysterectomy. We must remember that the Americans, and many British operators, favour amputation below the level of the os internum, or, in other words, through the cervix. No endometrium is left behind, as it does not extend below the os internum. Personally, I find that the patients, as a rule, do very well after cervical amputation.

As these notes are devoted to the present position of our knowledge with regard to the treatment of uterine fibroids, we must be careful to define the present position of our ignorance about the same subject. The "flap" question now under consideration and the right course with respect to the ovaries remain unsolved problems. I have designedly implied above that, though it would seem best to save some of the endometrium or mucous membrane of the body of the uterus, experience shows that cases fare well when none is left.

Theories on this or on any other disputed point of treatment based on the low mortality of some fifty or a hundred hysterectomies by one clever operator are seldom, if ever, convincing to others. The successful surgeon is often strongly biassed as to the value of some detail in treatment which he adopts, and hence may ascribe good or bad after-results to a wrong cause. We read of one operator attributing his good results in a series of abdominal sections to his practice of flushing the peritoneal cavity with saline solution, whilst another argues that his equally-satisfactory results are due to his principle of drying the peritoneum thoroughly in every case. The same fallacy underlies arguments about flaps. It is certainly a mistake to cut very large flaps of uterine tissue, although they often give no trouble. But the share which the practice holds in respect to good and bad after-results can hardly be estimated with precision. In one case the uterine tissue may be healthy, in a second unhealthy, and in a third infested with small interstitial fibroids, the necessary enucleation of which involves much bruising of the flaps.

I have expressed an opinion above that the treatment of the ovaries in hysterectomy is a problem not satisfactorily solved. The older authorities who still operate maintain that it matters little whether the ovaries be left or removed. The younger school consider that it is a duty to save them. There remain others, myself among the number, who consider that experience shows that, taken as a whole, it is best to leave one ovary at least, provided that it be perfectly healthy, but that the advantages of the conservative treatment of the ovaries have been exaggerated, and that the ovaries have been known to give trouble after convalescence appeared complete.

Abel and Zweifel insist that not only must the ovaries be left, if we desire to save the patient from speedy and acute symptoms of the menopause, but that a portion of the endometrium or mucous membrance of the uterus proper must be saved as well. This theory is of course an argument in favour of long flaps In my own practice I find that the saving of a portion of the endometrium, that is to say, amputation above the level of the os internum, distinctly, though not very markedly, influences, in a favourable sense, the catamenial functions. For

that reason I observed above that it seems best to fashion the uterine flaps of a length just sufficient to include a little of the uterus above the cervix.

Reference has already been made to psychical disturbance after hysterectomy. It is by no means unknown, and its possible occurrence favours the conservative treatment of the ovaries. The precise danger, however, of removing both ovaries can never be estimated from statistics. Post-operative insanity has been known to follow many surgical procedures besides hysterectomy, whilst in several cases of that operation, in which it occurred, the patient had been subject to attacks of insanity already, although the operator had not been informed of the fact. Neurotic symptoms occurring during the menstrual period would seem to indicate that removal of the ovaries would make the patient more neurotic. Yet in two cases in my own practice where I removed both ovaries with large fibroids, the patients had been subject to syncope at the period quite independent of hæmorrhages; nevertheless the fainting-attacks disappeared entirely after the operation.

We must also remember, in our anxiety to avoid a stormy menopause, that some women, when it occurs prematurely owing to removal of the ovaries, care little about their flushings and faintings, just as many subjects trouble little about these symptoms when they set in naturally and at the usual age. Others worry under an artificial, just as under a normal, menopause about the slightest flushings even at long intervals.

Thus evidence seems rather in favour of the conservative treatment of the ovaries; yet its advantages at the best are certainly not great, and in no individual case can they be accurately estimated. Unfortunately evidence has also proved that there are disadvantages associated with this treatment. A piece of Fallopian tube left with an ovary may inflame or even suppurate. The spared ovary itself may become the seat of a new growth. It is certain that an inflamed ovary and the tube should always be removed; and when the inflammatory disease affects both appendages, the operator should never scruple to remove them.

Enough has been said to show that the present condition of our knowledge about the effects of removing both ovaries

is by no means satisfactory. Several hundred after-histories are required, and they should be collected by practitioners and registrars who are in a position to watch them for many years. A single series reported by one operator and his assistants is of small value for many reasons, and can never convince those who differ from the reporter as to his theories and practice. Credit, nevertheless, must be awarded to all who have published such reports[1] as, however unwittingly prejudiced these operators may be, they have added much to our knowledge of the physiology of the ovaries.

The abdominal wound has to be closed, and we ought to adopt that method which will ensure a firm cicatrix so that no hernial pouch can form. These herniæ give rise to great discomfort, which we must take into account, since many fibroids suitable for different reasons for operation do not make the patient feel uncomfortable. The herniæ are also areas of possible danger, firstly through incarceration of intestine—strangulation is very improbable—and secondly through sloughing of the thinned sac, a complication usually fatal; but in women in easy circumstances these ventral herniæ rarely cause more than discomfort.

Unfortunately, although we ought to adopt the method of suture which will absolutely ensure a firm cicatrix, that method remains unknown. Deep sutures of silkworm-gut or silk including all the layers of the wound often ensure perfect union, provided that they are not tied too tightly or placed too close together or too far apart. Care must also be taken not to include more than a quarter of an inch of the peritoneum on each side, especially in a thin subject. Notwithstanding all precautions, however, a bad hernia may develop.

Suture in layers, the opposite method, is popular at present, but it is open to great objections. It involves the leaving of a foreign body in tissues disturbed by respiration and other movements. Early or late suppuration is not unknown. The records of registrars and of medical societies bear witness to

[1] Especially to Dr. Crewdson Thomas. *See* "The After-Histories of 100 Cases of Supra-vaginal Hysterectomy for Fibroids," *Lancet*, Vol. I., 1902, p. 294. A series of 1,000 prepared with the same care would be of great value. Statistics of 44 cases in my own practice will be found in the second Harveian Lecture, *Lancet*, February 14, 1903.

this truth ;[1] and I know of several such cases which have occurred within the last twelve months and have not as yet been reported ; and I must add two which I have observed in my own operative practice. The supporters of this method of suture may remind us, I must admit, that suppuration is not necessarily followed by hernia. Ten years ago I removed a double pyosalpinx from a very fat, unhealthy patient, using Keith's drainage-tube. The wound suppurated, yet the cicatrix is at the present day perfectly firm and there is not the least trace of hernia.

Altogether, carefully-applied deep interrupted sutures do best. In very fat subjects, where it is not easy to bring the cut edges of the sheaths of the recti into apposition, a few interrupted fine silk sutures are advisable. Catgut is apt to yield too soon, except when chromicised, and then it may act like a foreign body.

I have dispensed altogether with statistical tables which have been freely made public during the past ten years. They deserve study, but are apt to be very misleading. Tables prepared by the operators themselves are untrustworthy in demonstrating whether hysterectomy for fibroid be justifiable, just as they afford no certain proof of the superiority of one particular method, as has been already noted. The present position of our knowledge about hysterectomy is that, if it be performed on a hundred cases where the fibroid is small or of moderate size and gives rise to no severe symptoms, it is conceivable that all may recover, especially should the operator happen to be an expert who had removed many abdominal tumours before he undertook the first of his hundred hysterectomies. These good results in simple cases are used as an argument in favour of operation, whilst on the other hand the opponents of hysterectomy as routine treatment look upon a very low mortality rather as a reproach than a credit to the operator, implying that many hysterectomies in a brilliant series were quite unnecessary.

We must not forget that statistics of abdominal operations originated when Spencer Wells undertook those labours which played such a large share in the establishment of ovariotomy

[1] *St. Bartholomew's Hospital Reports*, Vol. XXXV. (1899), p. 26; *Middlesex Hospital Reports* for 1897, Case XXIV., pp. 222, 223 (suppuration within three weeks); *Trans. Obst. Soc. Lond.*, Vol. XLIV., 1902, p. 183 (a year after operation). In all these cases the operators were surgeons of great ability.

as a justifiable surgical procedure. The removal of an ovarian tumour was shown to be necessary, to be practicable, and to be fairly safe should certain precautions be taken. When Wells began his first series, Baker Brown had given up the operation ; very few others were attempting it, and most men were lapsing into the old state of indifference, if they were not loudly protesting against it.[1] Current statistics about hysterectomy for fibroid are based on very different conditions both in respect to the nature of the disease and the attitude of the profession towards abdominal operations. Nowadays nobody can deny with reason that an ovarian tumour should be removed, save under certain quite exceptional circumstances ; the same cannot be said of uterine fibroids. At the same time hysterectomy for fibroids is largely practised. It was the opponents of ovariotomy—an operation then rarely attempted —who were in a majority when Wells published his earliest statistics. At the present time when tables of hysterectomies are so largely published, it is the detractors of that operation who are in a minority. The old statistics of Wells convinced and converted the opponents of ovariotomy. The new statistics of hysterectomy fail to convince its opponents, who do not deny the low mortality, but who ask why the operators "wage war against all fibroids small or great."[2]

Statistics of hysterectomy, however, must be fairly judged on their own merits. They should never induce us to operate upon every fibroid that henceforth comes under our care. They may reasonably fail to convince us that every case which they include was the better for operation. Still they show that recovery is almost certain when a fibroid of a moderate size is removed by an experienced operator. That the patient is always in certain respects a gainer by the removal of her fibroid, I have already demonstrated. In the worst cases, where operative interference is most necessary, the mortality remains considerable. These facts must be seriously taken into account by all who have cases of fibroid disease of the uterus under their charge.

[1] Spencer Wells : *On Ovarian and Uterine Tumours : their Diagnosis and Treatment*, 1882, p. 196.

[2] Murdoch Cameron, *loc. jam cit.*